DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-34

2. STATE: Minnesota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
§1916 of the Act; 42 CFR §§447.53-.55

7. FEDERAL BUDGET IMPACT:
a. FFY '04 ($7,795)
b. FFY '05 ($8,579)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Preprint pp 41
Preprint pp. 56a, 56f
Att. 4.18-A, pp. 1, 1a, 2, 3
Att. 4.18-C, pp. 1, 1a, 2, 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Preprint pp. 56a, 56f Preprint p 41
Att. 4.18-A, pp. 1, 2, 3
Att. 4.18-C, pp.1, 2, 3

10. SUBJECT OF AMENDMENT:
Recipient Cost Sharing and Similar Charges

11. GOVERNOR'S REVIEW *(Check One)*:
x GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
// Mary B. Kennedy – signature //

16. RETURN TO:
Stephanie Schwartz
Minnesota Department of Human Services
Federal Relations Unit
444 Lafayette Road No.
St. Paul, MN 55155-3852

13. TYPED NAME:
Mary B. Kennedy

14. TITLE:
Medicaid Director

15. DATE SUBMITTED:
October 3, 2003

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
10/3/03

18. DATE APPROVED:
12/23/03

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/03

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

Revision: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: MINNESOTA

Citation

4.10 Free Choice of Providers

42 CFR 431.51
AT-78-90
46 FR 48524
48 FR 23212
§1902(a)(23) of the Act; P.L. 100-93 (§8(f)); P.L. 100-203 (§4113)

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. Providers who elect not to provide services based on a history of bad debt, including unpaid copayments, shall give recipients advance notice and a reasonable opportunity for payment. Recipients retain the ability to seek services from other enrolled providers.

(b) Paragraph (a) does not apply to services furnished to an individual -

(1) Under an exception allowed under 42 CFR §431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR §431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with §1902(p) of the Act, or

§1902(a)(23) of the Act; P.L. 105-33 (§4724(d)(2))

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services.

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in §1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under §1905(a)(4)(C).

Revision: HCFA-PM-91- (BPD) OMB No.: 0938-
August 1991

State/Territory: MINNESOTA

Citation
42 CFR 447.51
through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

☐ Not applicable. There is no maximum.

Revision: HCFA-PM-91- (BPD) August 1991 OMB No.: 0938-

State/Territory: MINNESOTA

Citation	4.18(c)(3) (Continued)	
447.51 through 447.58	(F)	Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
	(G)	Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.
	☐	Not applicable. There is no maximum.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

	Type of Charge			
Service	**Deductible**	**Coinsurance**	**Copay***	**Amount and Basis for Determination**
• nonpreventive visit			X	$3 per office visit. No copayment for an office visit for physical therapy, occupational therapy, speech therapy, or mental health services. Only one copayment per day, per treating provider. The average payment for a nonpreventive visit exceeds $50.01.
• eyeglasses			X	$3. Only one copayment per day, per treating provider. The average payment for eyeglasses exceeds $50.01.
• nonemergency visits to a			X	$3 per visit. Only one copayment per day, per hospital-based emergency room treating provider. The average payment for a non-emergency visit to a hospital-based emergency room exceeds $50.01~~, in accordance with 42 CFR §447.54(a)(3)~~.

* In addition to the services and recipients not subject to a copayment in §1916(a)(2), and in 42 CFR §447.53(b), the following are not subject to copayments: 1) services that are 100% federally funded and are provided by an IHS or 638 facility; and 2) services paid for by Medicare, for which the Department pays the Medicare coinsurance and deductible.

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A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

	Type of Charge			
Service	**Deductible**	**Coinsurance**	**Copay***	**Amount and Basis for Determination**
• prescribed drugs:				
a. brand-name		X		a. $3 per prescription. No copayment for: 1) anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. The average payment for brand-name prescriptions exceeds $50.01.
b. generic		X		b. $1 per prescription. No copayment for: 1) anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. The average payment for generic prescriptions is $10.01 to $25.00.

* In addition to the services and recipients not subject to a copayment in §1916(a)(2), and in 42 CFR §447.53(b), the following are not subject to copayments: 1) services that are 100% federally funded and are provided by an IHS or 638 facility; and 2) services paid for by Medicare, for which the Department pays the Medicare coinsurance and deductible.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers cannot deny services to ~~individuals~~ recipients unable to pay copayments.

The method for determining whether ~~an individual~~ a recipient is unable to pay is the ~~individual's~~ recipient's assertion that he or she is unable to pay the copayment. Any uncollected copayment amount is considered a debt to the provider.

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State: MINNESOTA

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR §447.53(b) are described below:

- Department bulletins and provider updates
- Department's "Minnesota Health Care Programs" provider manual
- State Register notice published June 30, 2003
- recipient notice
- Department's Eligibility Verification system (automated telephone and on-line information service for providers)
- Automated payment system that edits billings for services excluded from copayments. These services are paid at normal rates. If, after a copay is paid, the system receives corrected information regarding the excluded status of a recipient or regarding an excluded service, the system is capable of reprocessing the claim.

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

- $20 per month, per person, for prescription drug copayments

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

A. The following charges are imposed on the medically needy for services:

	Type of Charge			
Service	**Deductible**	**Coinsurance**	**Copay***	**Amount and Basis for Determination**
• nonpreventive visit			X	$3 per office visit. No copayment for an office visit for physical therapy, occupational therapy, speech therapy, or mental health services. Only one copayment per day, per treating provider. The average payment for a nonpreventive visit exceeds $50.01.
• eyeglasses			X	$3. Only one copayment per day, per treating provider. The average payment for eyeglasses exceeds $50.01.
• nonemergency visits to a hospital-based emergency room			X	$3 per visit. Only one copayment per day, per treating provider. The average payment for a non-emergency visit to a hospital-based emergency room exceeds $50.01~~, in accordance with 42 CFR §447.54(a)(3)~~.

* In addition to the services and recipients not subject to a copayment in §1916(b)(2), and in 42 CFR §447.53(b), the following are not subject to copayments: 1) services that are 100% federally funded and are provided by an IHS or 638 facility; and 2) services paid for by Medicare, for which the Department pays the Medicare coinsurance and deductible.

DEC 2 2 2003

TN No. 03-34
Supersedes
TN No. 03-32 (85-63)

Approval Date _____

Effective Date 10/1/03

OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: MINNESOTA

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge: Deductible	Coinsurance	Copay*	Amount and Basis for Determination
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a. brand-name		X		a. $3 per prescription. No copayment for: 1) anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. The average payment for brand-name prescriptions exceeds $50.01.
b. generic		X		b. $1 per prescription. No copayment for: 1) anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. The average payment for generic prescriptions is $10.01 to $25.00.

* In addition to the services and recipients not subject to a copayment in §1916(b)(2), and in 42 CFR §447.53(b), the following are not subject to copayments: 1) services that are 100% federally funded and are provided by an IHS or 638 facility; and 2) services paid for by Medicare, for which the Department pays the Medicare coinsurance and deductible.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- recipient notice
- Department's Eligibility Verification system (automated telephone and on-line information service for providers)
- If, after a copay is paid, the system receives corrected information regarding the excluded status of a recipient or regarding an excluded service, the system is capable of reprocessing the claim.

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

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